Questions and Answers about C. P. S.

Question: Under the new C.P.S. medical contract, are the $25 and $10 allowances for x-ray and laboratory services renewed each year? If so, how can the physician know the date when a C.P.S. patient's allowances are renewed?

Answer: Yes, these allowances are renewed each contract year. (A "contract year" covers one year from the effective date of the member's enrollment in C.P.S. under the new medical contract, or one year from the date the member's coverage was converted from the old to the new medical contract.)

The following procedure has been established so that physicians will know the status of a C.P.S. patient's x-ray and laboratory allowances: When a physician member who performs these services in his own office submits his bill to C.P.S., he is automatically sent a form which indicates (1) the amount which will be paid by C.P.S., (2) the amount of the $25 and $10 allowances which remains, and (3) the date when the allowances will be renewed.

Question: I have two questions regarding exclusions from coverage under the Direct Payment Program: (a) Are tonsillectomy and adenoidectomy and pregnancy excluded? (b) Have athletic and occupational injuries recently been removed from the list of exclusions?

Answer: (a) Benefits for tonsillectomy and adenoidectomy are immediately excluded when a C.P.S. member transfers from group membership to the direct payment program. (Code number shown on identification card is "OCC ——.") Benefits for pregnancy which may have been held under group membership (except surgical services for ectopic pregnancy and repair of conditions arising from prior pregnancy) are excluded nine months after transfer from group to direct payment membership.

(b) Yes, athletic injuries and occupational injuries not covered by Workmen's Compensation were recently removed from the list of exclusions under the direct payment program.

Question: How many persons must be enrolled on a contract in order to apply for the C.P.S. provisions of $50 for hospitalization for childbirth and $50 for professional services for maternity?

Answer: The $50 allowance for hospitalization for childbirth applies when *two or more persons* are enrolled on the *same* contract—but not when they are enrolled on separate contracts, as when a husband and wife are enrolled in separate C.P.S. groups. The $50 allowance toward the cost of professional services for maternity applies whether or not any other persons are enrolled on the expectant mother's two-visit-deductible contract.

In both instances, the member must have met the requirements of her waiting period before she is eligible for these benefits.

Question: Are preexisting conditions covered under the new statewide Individual Family Plan contract? (Code on identification card is "064—".)

Answer: Under this contract, all preexisting conditions are excluded for the first year of membership. The decision as to the preexistence of a condition is based on generally accepted medical knowledge and experience—not on the member's awareness of symptoms of the ailment.

After one year's membership, preexisting conditions are covered in accordance with terms of the contract, except for any condition(s) which may have been waived at time of joining.

Question: Are veterans of the Korean War eligible for out-patient medical care under the Home Town Care Program?

Answer: Confusion regarding the eligibility of Korean War veterans stems from the fact that the United States has not made a formal declaration of war, and because disabilities incurred in peacetime enlistments in the Armed Forces are not handled by the Veterans Administration in the same manner as service-connected disabilities received in time of war.

To rectify the situation, the 82nd Congress passed Public Law 170, which provides that disabilities occurring on or after June 27, 1950 (date of the start of the Korean War), shall be considered the same as service-connected disabilities incurred in time of war. Thus, Korean War veterans are eligible for the same benefits provided for World War I or World War II veterans under the Home Town Care Program.

Question: What is the procedure for obtaining drug prescriptions under the Veterans Program?

Answer: The prescription should be written on California Pharmaceutical Association-Veterans Administration prescription blanks (available from any member pharmacy participating in the program) and should be for an amount not exceeding what is needed for one month's treatment. The prescription should be given to the veteran patient, who will have it filled at a pharmacy handling VA prescriptions. The physician should see that the prescription is used only for treatment of the veteran concerned, and that it is for the service-connected disability currently under authorized treatment.